Medicaid Reform Ideas for the State of Kansas

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2011

About Us

The Association of Community Mental Health Centers of Kansas, Inc., represents the 27 licensed Community Mental Health Centers (CMHCs) in Kansas who provide home and community-based, as well as outpatient mental health services in all 105 counties in Kansas, 24-hours a day, seven days a week.

In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. The CMHC system is state and county funded and locally administered.

In Kansas, you first must be designated by your County to serve as the CMHC to the county residents, then you must secure a license from the Kansas Department of Social and Rehabilitation Services (SRS), to become the publicly funded CMHC and recognized as such by the State of Kansas.

Consequently, service delivery decisions are made at the community level, closest to the residents that require mental health treatment. Each CMHC has a defined and discrete geographical service area. Together, they employ over 4,500 professionals.

The Association of Community Mental Health Centers of Kansas, Inc., is pleased to offer its input to the Brownback Administration on Medicaid reform ideas and opportunities for the State of Kansas. We are confident that through a partnership with providers and stakeholders alike, the Administration can address growth in Medicaid while improving quality, efficiency and effectiveness through tools such as value-based purchasing; improving care coordination; better use of technology and investing in wellness programs. With this in mind, the Administration should:

Executive Summary of Recommendations

- Continue to support the partnership between SRS and KHS in managing Medicaid mental health services.
- Support care coordination efforts for high utilization of inpatient services.
- Continue the carve-out approach for mental health and substance abuse services and preserve the administration and oversight of those programs within SRS so that the entire mental health and substance abuse systems have coordinated oversight.
- Support CMHCs becoming health homes for adults who experience SPMI and children/adolescents who experience SED.
- Invest in disease management protocols.
- Invest in early intervention and prevention programs across all disease states. Furthermore, the Administration should look for ways to address risk factors for disease states.
- Pursue developing and implementing a Voluntary Health Care Cost Containment Initiative.
- Work with the provider community to implement payment reforms.
- Examine opportunities for managed care for long-term care that further enhance existing efforts by the PACE program.
- Continue investing in cost effective HCBS Programs.
- Promote and support coordinated and collaborative pilot projects inclusive of mental health, substance abuse, aging, and primary care safety net systems that build on existing pilot efforts.

Executive Summary of Recommendations, cont...

- Maximize opportunities under the Affordable Care Act of 2010.
- Implement a gatekeeper program targeting older adults who are at risk of institutionalization.
- Work with SRS, KHS, the Association of CMHCs of Kansas, and mental health system stakeholders to determine an adequate mental health and substance abuse benefit package for the benchmark plan.
- Implement practice guidelines, provider feedback and retrospective reviews for Medicaid mental health prescription drugs.
- Implement opportunities for pharmacy savings outlined in this document.
- Examine what cost sharing is occurring in Kansas Medicaid presently and identify opportunities that might be worthwhile to explore that would be affordable for Medicaid recipients in Kansas.
- Support all mental health services purchased by the State be coordinated and contracted for within the single State agency that manages and oversees mental health programs, which is currently SRS.
- Direct Executive Branch agencies who purchase health care services to contractually require coordination and integration of care and have measureable outcomes that demonstrate coordinated care.
- Invest in family preservation as well as the Family Assessment and Referral Program to divert children from foster care placement.
- Support the optional Medicaid mental health services in the Medicaid State Plan, as doing otherwise will increase costs to the State by driving people to higher cost mandatory services or by losing federal matching funds for services the State would need to provide with SGF dollars.

We appreciate the opportunity to provide the Administration with these ideas and input. We strongly encourage provider and stakeholder participation throughout the decision making process to ensure broad-based input and the greatest opportunity for buy-in.

The CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 27 licensed CMHCs form an integral part of the total mental health system in Kansas. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay.

This makes the community mental health system the "safety net" for Kansans with mental health needs. Collectively, the CMHC system serves over 115,000 Kansans with mental illness.

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We would like to begin by pointing out why funding mental health is actually part of the solution to the State's budget issues and how it aligns well with the priorities of the new Administration:

- The State can either invest in the public mental health system or pay a greater price through increased psychiatric hospitalization and primary care costs, greater reliance correctional facilities, homelessness, and other costs to society including lost productivity and suicide.
- We know it costs on average, $428 per day for treatment at one of our State psychiatric hospitals; $80 per day on average to be incarcerated at Larned Correctional Mental Health Facility; $10 per day on average for Medicaid expenditures for community-based mental health treatment; and $22 per day on average for Medicaid expenditures for the most chronic mental health conditions. This is consistent with other data which confirms community-based treatment for mental illness is the best value.
- Investing in community-based mental health services directly lowers healthcare costs. Treatment for mental disorders is associated with a 20 percent reduction in the overall use of health care services. At a time when the State is struggling with containing the costs of health care, paying for the cost of community-based mental health treatment is part of the solution to our State's budget crisis.
- Good mental health enhances the workplace; a high percentage of lost productivity, staff absences and errors on the job is due to emotional problems, alcohol and/or drug abuse.
- Children learn better in a school environment where early intervention of mental health services is available.
- Effective community-based mental health treatment and support services, as well as newer medications, promote economic stability by permitting thousands of persons with serious mental illness to hold meaningful jobs and maintain productive lives in their own communities.

Existing Efforts Occurring in the Medicaid Mental Health Managed Care System

In an effort to improve on the delivery of Medicaid services at a lower cost, the Medicaid mental health managed care organization, Kansas Health Solutions (KHS), along with our long-time partner, SRS, have identified the following priority initiatives designed to promote recovery and improve the quality of Medicaid funded mental health services while controlling costs:

1. Utilization Review. Utilization review practices will identify and eliminate unnecessary high utilization with the goal to demonstrate savings compared with the FY 2011 Fall Consensus Caseload Estimate in both FY 2011 and FY 2012.
2. Intensive Services for Persons with Extraordinary Needs. Ensuring effective community services are provided to persons with extraordinary needs so they can be safely and effectively served, resulting in a measurable reduction in the need for inpatient and residential treatment.

3. Care Coordination. Improve care coordination between physical and mental health treatment for persons with severe mental illness and other chronic health conditions, resulting in improved health and wellness and a reduction in Medicaid funded physical health costs. A cooperative pilot project between the Association of Community Mental Health Centers of Kansas, Kansas Health Solutions and the Kansas Association for the Medically Underserved (KAMU) began in the spring in 2009 by pairing 6 CMHCs with their respective Primary Care Clinic and to identify some of their highest risk patients that have both a mental health diagnosis and a chronic care diagnosis. The integration model provides access to a team-based approach. The project exceeded its expectations and currently has 10 pairs participating. The pilot began October 1, 2010 and is expected to run through September 30, 2011. The project focus is on the local perspective, where each site will focus on differing aspects of the interface between primary care and behavioral health, and adopt different aspects for improving the quality of care in their highest risk patients. Each participating pair submits quarterly reports to KHS that address their process and model for integration and coordination, identified gaps with their current process and process improvements, along with quarterly SF-12 scores for all participating consumers. Each pair has identified shared patients (including Medicaid, Medicare, private insurance and uninsured). The local perspective focus allows each pair to determine how they identify the co-morbid population (i.e. all patients in a group can share the same co-morbidities or have different co-morbid diagnoses). Goals of the Pilot include:

   - Improved clinical outcomes of our highest risk/most costly patients
   - Simultaneously focus on health and behavioral health issues
   - Co-manage chronic patients and monitor high risk patients with PCP
   - Improved health outcomes
   - Decreased costs
   - Decreased hospitalization

We know from existing data that costs for KHS members receiving both outpatient and inpatient services is roughly 6 times greater than for those receiving outpatient only. Based on data demonstrating that mental health costs account for 10 percent of Medicaid dollars and assuming a similar disparity in costs on the medical side for inpatient/outpatient and outpatient only, the Association predicts that by implementing integrated care across the state, the number of consumers receiving both outpatient and inpatient services will decrease, thus lowering the cost gap. Similar integrated care initiatives in other states have demonstrated:

   - Reduced ER Utilization
   - Reduced In-patient Admissions
   - Reduced Specialty Referrals
   - Increased Patient Satisfaction
   - Increased Primary Care Utilization
   - Improved Outcomes

4. Prescriber Practices. Identify concerning mental health medication prescriber practices for children in State custody or on the SED Waiver and provide expert clinical guidance to improve practices where problems are found. KHS is also developing prescribing guidelines to distribute across its provider network.

These efforts by KHS that have been outlined above are expected to realize an estimated $37.8 million AF savings in Medicaid mental health and physical health expenditures across FY 2011 and FY 2012.

Recommendation: Continue to support the partnership between SRS and KHS in managing Medicaid mental health services.

Care Coordination Proposal for High Utilization of Inpatient Services

We know that KHS will soon begin a program of Care Coordination for KHS Members who have had three or more psychiatric hospitalizations in the preceding 12 months. In this program, KHS Members who have been identified as appropriate for the project (i.e., those Members who have had three or more psychiatric hospitalizations in the year) will be assigned to a KHS Care Coordinator. The Care Coordinators will either be individuals licensed at the Masters level or higher in Social Welfare or Psychology or licensed Registered Nurses with Mental Health experience. These Care Coordinators will maintain telephone contact with the Members (and/or parents/guardians) as well as Providers involved in the care of the Members. The Care Coordinators will function to support Members in staying engaged with outpatient care and will monitor for signs that the Member may be moving toward a higher level of care. When there is an indication that a Member's progress has slowed or reversed, placing the Member at risk of inpatient treatment or other institutionalized level of care, the Care Coordinator will be in contact with the Member's Providers to make the Providers aware of the situation and to collaborate with the Member and Providers in developing a plan of care that will be designed to reduce the likelihood of the Member requiring an institutional level of care.

Part of this program will involve evaluating the outpatient plan of care for adequacy for the specific Member involved. For the Members eligible for this program, it is anticipated that they will benefit from intensive delivery of outpatient and rehabilitative Mental Health services to maintain tenure in the community setting. With longer stability in the community setting, and commensurate with principals of rehabilitation, the intensity of these outpatient and rehabilitative services would be expected to decrease over time.

Recommendation: Support care coordination efforts for high utilization of inpatient services.

Carve-In vs. Carve-Out

While we understand there is an interest in exploring an integrated carve-in managed care approach to managing Medicaid, **a capitated carve-out structure can be administered effectively with responsibility for managing and integrating the mental health and substance abuse benefit, and incorporating care coordination across physical health. Numerous reports and studies from both the private and public sector suggest that a carve-out strategy can reduce total costs for mental health and substance abuse services, even when the number of service users increase. One study found that neither HMOs nor primary-care gatekeepers were viewed as especially effective in coordinating substance abuse treatment with primary care.** This is why mental health and substance abuse services were carved out in the first place. States taking these carve-out approaches are seeking to reap the advantages of specialized management without the accompanying aspects of for-profit managed care that often raise concern among enrollees and providers. Public and nonprofit management are presumed to be less likely to over-manage care because they cannot distribute surplus revenues to investors. At the present time, we have two separate carve-outs, one for mental health, which is a Prepaid Ambulatory Health Plan (PAHP) and one for substance abuse, which is a Prepaid Inpatient Health Plan (PIHP). The difference between the PAHP and the PIHP is that the PAHP does not bear the responsibility for paying or managing facility based care (inpatient). The PAHP is not at-risk while the PIHP is at-risk. **We support the PAHP and the PIHP becoming one integrated carve-out that is either capitated (global budget for total resources available for care delivery) or alternate form of payment.**

Evidence supporting a carve-out approach includes:

- Ensures provision of care by specialized MCOs that are experienced with the complex, long-term challenges presented by SPMI population (OIG, 2000, *Early Lessons*).
- Offers more specialized and creative outpatient services (OIG, 2000, *Changes).*

- Increases utilization of mental health services (OIG, 2000, *Changes*).
- Achieves program savings by setting limits on mental health costs and shifting treatment from inpatient to outpatient settings (OIG, 2000, *Changes*).
- Reduces risk to MCOs by separating specialty treatment that require a high level of care and cost (OIG, 2000, *Changes*).
- Ensures funding is used to provide specialty services because funds are separated from general health funding (OIG, 2000, *Changes*).
- Decreases wait time for outpatient services (OIG, 2000, *Changes*).
- Increases outpatient services for children's mental health (OIG, 2000, *Children's Access*).
- Decreases utilization of inpatient services, especially for children (OIG, 2000, *Children's Access*).
- Appropriate utilization management with a range of treatment options may help standardize care and assure adherence to empirically validated treatment protocols (Rothbard, 2002).
- Favors outcomes-orientated monitoring rather than process-orientated regulation (Rothbard, 2002).
- May increase beneficiaries' time in paid employment (Rothbard, 2002).
- Yields cost savings, especially for the Social Security Income (SSI) and SSI-related population (Lewin, 2009).
- Decreases prescription drug costs (Lewin, 2009).
- Reduces emergency room use (Anderson, 2002).
- Decreases consumption of medical resources when mental health diagnosis and treatment is accurate and timely (Anderson, 2002).
- Results in a higher quality of care due to the adoption of treatment protocols that specify a certain standard of care (Callahan, 1995).
- Decreases inflation-adjusted per-enrollee spending on substance abuse treatment, even after accounting for increased administrative costs (Shephard, 2001).
- Improves penetration rates (Shephard, 2001).
- Expands intermediate residential services (Shephard, 2001).
- Decreases average costs per unit for the majority of services (Shephard, 2001).
- Eliminates need for behavioral health providers to choose among rival HMOs which would disrupt existing referral relationships (Hodgkin, 2004).
- Increases investment in information systems to track client utilization and to process invoices and payments (Hodgkin, 2004).
- Reduces total costs for mental health and substance abuse services, even when the number of service users increases (Grazier, 1999).
- Decreases number of outpatient mental health visits (Grazier, 1999).
- Increases the likelihood of receiving outpatient mental health services (Grazier, 1999).

Most of the behavioral health (mental health and substance abuse) clients don't come into treatment through the health door, but rather through the behavioral health system. You can't serve them if you can't engage them in a partnership with the care system. **The Administration needs to build on the existing behavioral health care system to address concerns with this population. Most Medicaid managed care plans don't have any significant experience or success in properly engaging and serving a group that needs lots more outreach, support, crisis assistance, rehabilitation and peer support than the typical HMO Medicaid beneficiary.** Our greatest concern with a carve-in approach is that large MCOs/HMOs would not effectively incorporate mental health and substance abuse services. Historically, in these situations, MCOs/HMOs dismantle these services as physical health needs consume the available resources and leave mental health and substance abuse as afterthoughts. **We urge you to build on the system that best knows and serves some of our most vulnerable Kansans, and let that system reduce costs by implementing innovations that will improve the delivery and coordination of behavioral and medical care, while greatly cutting down on costly and avoidable emergency room and inpatient hospital visits and improving overall health outcomes.**

Recommendation: Continue the carve-out approach for mental health and substance abuse services and preserve the administration and oversight of those programs within SRS so that the entire mental health and substance abuse systems have coordinated oversight.

Health Homes

Behavioral health providers with specialty service capacity should be designated as health homes for consumers with serious mental illness and/or substance abuse issues and facilitate the integration of physical and behavioral health. This will be a critical step to improving care coordination, improving health outcomes, and reducing overall health care expenditures for adults with SPMI and children with SED. The Department of Social and Rehabilitation Services (SRS) has voiced support for moving in this direction and the Association is proceeding to assist CMHCs in becoming health homes. We ask that the Administration support these efforts. In this health home approach, primary care and behavioral health professionals will be co-located and offer enhanced services in several ways:

- Improved behavioral health outcomes that bear on wellness issues such as obesity and smoking.
- Easy access to mental health treatment for people with other serious or chronic illnesses, such as diabetes or cardiac conditions, whose recovery is impaired by a co-occurring mental health disorder, such as depression.
- Greater access to appropriate treatment for mild or moderate mental health disorders, either through direct services from the co-located mental health specialist or through improved treatment of these disorders by primary care providers as a result of the ease of consultation.
- Improved referral and linkage with community mental health specialty care for more complex cases.

Community mental health centers often act as the primary or only source of care for individuals with severe mental illness. This further highlights the importance of a CMHC serving as the medical home for adults who experience SPMI and children/adolescents who experience SED.

The Association has studied the medical home model practices carried out in Missouri. *Mental Health Community Case Management and Its Effect on Healthcare Expenditures* published by J. Parks, MD; Tim Swinfard, MS; and Paul Stuve, PhD is an excellent source of information regarding the benefits of utilizing community mental health centers has a medical home, and is included with our reference materials. We propose to utilize resources such as this to launch a health home pilot project that expands to cover multiple sites across the state.

Total costs increased for the sample during the two years before enrolling in Community Mental Health Case Management (CMHCM), with the average per user month (PUPM) total Medicaid costs increasing by more than $750 during that time. This trend was reversed by the implementation of CMHCM. After a brief spike in costs during the CMHCM enrollment month, the graph shows a steady decline over the next year of $500 PUPM, even with the overall costs now including CMHCM services.

This is a tremendous opportunity for the State of Kansas. This brings an enhanced FMAP rate of 90% for eight quarters. As highlighted above, there is proven ability to improve cost, quality, access, functionality and quality of life via health homes through partnerships between CMHCs and primary care safety net clinics.

Recommendation: Pursue the federal planning funding that is available, in the amount of $500,000 related to Medicaid health homes, that KHS be an active member of the planning group along with SRS, and that ultimately CMHCs be an option for Medicaid eligibles as their health home.

Disease Management Protocols

We propose that development and implementation of mental health disease management protocols be included in Medicaid reforms in Kansas. Specifically, disease management protocols for any of the following diagnoses:

New onset or first diagnosis of the following disorders:

- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Major Depressive Disorders that are moderate or severe in nature
- Bipolar I Disorder
- Bipolar II Disorder
- Panic Disorder
- Posttraumatic Stress Disorder
- Obsessive Compulsive Disorder
- Attention-Deficit/Hyperactivity Disorder
- Conduct Disorder
- Oppositional Defiant Disorder
- Borderline Personality Disorder

Ongoing severe mental illness involving the following disorders:

- Schizophrenia
- Schizoaffective Disorder
- Major Depressive Disorders that are moderate or severe in nature
- Bipolar I Disorders that are moderate or severe in nature
- Panic Disorder
- Borderline Personality Disorder

For new diagnoses, there would be an initial service package targeted to the specific disorder. This package would include service expectations, such as how many outpatient psychiatric visits would be anticipated in the first 6 months, how many sessions of individual therapy would be anticipated in the first 6 months, and so forth. This package would be designed to have the most benefit for the Member for secondary and tertiary prevention. Both the Member and the Provider(s) would be made aware of the service package identified for the Member's disorder. The service package would be expected to be relatively more intense initially, but as the Member experiences improvement and recovery, the intensity would be expected to decrease. Care coordinators would maintain telephone contact with the identified Members, to evaluate for appropriateness of the treatment packages and any adjustments that would be warranted. An equally important goal of care coordination would be maintaining vigilance for any indication that the Member is not experiencing improvement or is becoming at risk of needing a higher level of care. Care coordinators would have ongoing contact with Providers, as needed, and especially if there are indications of failure of the outpatient program, with the goal of allowing the Provider to make adjustments to the course of treatment to maximize the Member's chance for recovery.

Retrospective review would be made of claims data, and Providers who consistently fail to deliver a minimally appropriate amount of services to Members with a new diagnosis would be engaged in corrective action. Similarly, Providers who fall substantially below peers in terms of outcomes, such as hospital usage, return to employment, school performance, etc., will be engaged in corrective action. Providers who show exemplary outcomes in terms of these same indicators will be studied to identify findings that may be of benefit elsewhere in the state. Providers who design and implement treatment packages that are congruent with the relevant disease management protocols would

receive additional financial compensation, which would be derived from cost savings achieved by this program, provided that they meet quality indicators for hospital utilization, independent living (adults), employment (adults), residing in family home setting (for youth), and A/B/C grades in school (youth).

Part of the disease management protocols would include prescribing guidance for psychiatric medication. Providers would proactively be given current best practice guidance for the particular disorder they have newly identified in the Member. Pharmacy claims data would be monitored for evidence of deviation from the best practice guidance. In cases where the deviation is substantial, outreach would be made to the Provider, with the goal of either educating the Provider to self-correct the pattern or identifying a reasonable explanation for deviation from the best practice guidance. In the case of a recalcitrant prescriber, a plan of corrective action may be occasionally required.

Disease management protocols for individuals with Severe Mental Illness (SMI) would be similar in nature to those described above. In the case of SMI, however, the service package would likely include rehabilitation services that would not necessarily be appropriate to all individuals with a new onset mental illness. Likewise, as above, identification would be made of Members who are receiving less service than would be expected to be appropriate. Also as above, psychiatric prescribing best practice guidance would be developed and provided to providers based on the diagnosis being treated. Pharmacy claims would be monitored for deviation from prescribing best practice, and deviations would be addressed as above.

Opportunities for primary prevention are relatively rare in mental health due to the current funding structures. This proposal capitalizes on the opportunity to provide for robust secondary and tertiary prevention with strategically designed treatment packages. Assisting individuals with a new onset mental illness to achieve maximal recovery will yield cost savings in terms of less reliance on publicly funded programs as well as increased employment and tax base. Additional benefits include self-esteem and an increased sense of community.

Coordination and monitoring of outpatient mental health services would be key to this project. Costs would be reduced by secondary and tertiary prevention, with reduction in the likelihood of an individual with a new onset mental illness progressing to severe mental illness with associated disability and long-term reliance on publicly funded programs. By preventing progression to severe mental illness, it is anticipated there would be a reduction in the need for psychiatric rehabilitation services for individuals served by this project. Additionally, it is anticipated that adequate service delivery and care coordination would reduce utilization of hospital level of care.

This program would require start-up funding to facilitate the development of the disease management modules, including the best practice prescribing advice. Once implemented, this program would require funding for ongoing data analysis, including analysis of pharmacy claims, as well as staff to manage deviation from prescribing best practices and to provide ongoing care coordination.

Baseline pharmacy data and an ongoing data stream of pharmacy claims data would be required. Additionally, diagnosis data and claims data would be required, though these pieces of data are already available to KHS. For KHS to manage this program outside of KHS Members, access to this data would be required.
Direct cost savings would be expected to derive from decreased need for rehabilitation services and decreased use of institutional level of care. Additional direct cost savings would be expected to derive from correction of prescribing practices that deviate from established best practices. Indirect cost savings would be expected in terms of less reliance upon publicly funded programs as Members move into recovery and return to substantial employment.

Disease management programs can be estimated to reduce costs of treatment for managed diseases by 1 to 3% (NGA Center for Best Practices,1-16). If disease management resulted in 3% reduction in KHS claims, this would represent $5.1 million per year, based on FY10 claims paid.

For individuals accessing services in domains other than mental health, such as substance abuse services or physical health services, coordination with either those providers or with the managed care organizations providing those services would be required.

Initial direct cost savings would be anticipated within the first year of the project. The study *Is Early Intervention in Psychosis Cost Effective Over the Long Term?*, showed the total mean mental health service costs, per patient of the Early Psychosis Prevention and Intervention Center (EPPIC) group were approximately $48,000 lower than the control group. The EPPIC was found to have both better outcomes and fewer costs. Almost eight years after initial treatment, EPPIC subjects displayed lower levels of positive psychotic symptoms, were more likely to be in submission, and had more favorable course of illness than the controls. Each EPPIC patient costs on average $3,445 per year to treat compared with controls, who each costs $9,503 per year (909).

Recommendation: Invest in disease management protocols.

Prevention and Early Intervention

Moving further upstream with prevention and early intervention services to prevent health conditions from becoming chronic health conditions is an exciting opportunity and we hope to see opportunities for investment in this area for mental health (see attachment).

A recent review of health promotion and disease management programs found a significant return on investment for these programs, with the benefit-to-cost ratios, ranging from $1.49 to $4.91 (median of $3.14) in benefits for every dollar spent (DHHS, 2). The emphasis would be on preventing chronic diseases such as obesity, diabetes, cardiovascular disease and asthma.

According to literature, the per capita cost of many effective evidence based, community based disease prevention programs is under $10 per person per year. These programs are aimed at improving physical activity, nutrition, and preventing tobacco use. Therefore, the Trust for America's Health (TFAH) states net savings after intervention costs are estimated to be $26.9 million across the first two years; $155 million over five years.

Community-based mental health interventions are effective and cost-effective. The cost-benefit ratios for early treatment and prevention programs range from 1:2 to 1:10, meaning that a $1 invested yields $2 to $10 savings. People who have untreated mental health issues use more general health services (20 percent more) than those who seek mental health care when they need it.

Early geriatric screening and case management can result in a range of beneficial and cost-effective outcomes, including mental health benefits. In-home geriatric assessment, regular contact and a range of social services led to decreases in depression and increased mastery in life satisfaction. Significant decrease in institutionalization (15 percent reduction) was found for those who received intervention.

Emergency Department avoidance will clearly save money. It is widely known that inappropriate use of emergency departments is costly. Several projects across the nation have been successful in reducing this utilization, reducing costs and at the same time improving beneficiary quality of life. One firm, which KHS has contracted with since before it's inception, Criterion Health, Inc. has installed such a project in Kirkland WA, Dayton, OH and Denver, CO. Per their projections, a Behavioral Health Urgent Care Center that successfully redirected half of the people seeking ED services would result in a 10 per cent impact.

Early intervention and prevention services should be invested in by the State across all service systems. Research identifies, for example, what risk factors are for mental illness, yet most States, including Kansas, do not invest adequate resources to prevent the onset of this illness. Mental illness, as with other disabling illnesses, can be devastating for the individual and very costly for the State.

We know that treatment works and people can recover from mental illness. We know that psychosocial rehabilitation and family/group interventions in combination with medication can reduce the relapse rates for schizophrenia from 50 percent to 10 percent. We also know that the costs of not treating mental disorders outweigh the costs of treating them.

According to the World Health Organization (WHO), there are evidenced-based social, environmental and economic determinants of mental health.

Risk Factors	Protective Factors
Access to drugs and alcohol	Empowerment
Displacement	Ethnic minorities integration
Isolation and alienation	Positive interpersonal interactions
Lack of education, transportation and housing	Social participation
Peer rejection	Social responsibility and tolerance
Poor social circumstances	Social services
Poor nutrition	Social support and community networks
Poverty	
Discrimination	
Social disadvantage	
Violence	
Work stress	
Unemployment	

The WHO also goes on to say that individual and family-related risk and protective factors can be biological, emotional, cognitive, behavioral, interpersonal or related to the family context. For example, child abuse and parental mental illness during infancy and early childhood can lead to depression and anxiety later in life as well in next generations. Marital discord can precede conduct problems in children, depression among women and alcohol-related problems in both parents. Elderly people who are physically ill may suffer from a range of subsequent risk factors and problems such as chronic insomnia, alcohol problems, elder abuse, personal loss and bereavement.

Also noted by the WHO are main evidence-based factors that have been found to be related to the onset of mental disorders are outlined below.

Risk Factors	Protective Factors
Academic failure	Ability to cope with stress
Attention deficits	Adaptability
Caring for chronically ill patients	Autonomy
Child abuse/neglect	Early cognitive stimulation
Chronic insomnia	Exercise
Chronic pain	Feelings of security
Communication deviance	Good parenting
Early pregnancies	Literacy
Elder abuse	Positive attachment and early bonding
Emotional immaturity	Positive parent-child interaction
Excessive substance abuse	Problem-solving skills
Exposure to aggression and violence	Pro-social behavior

Family conflict Loneliness Low birth weight Low social class Medical illness Neuorochemical imbalance Parental mental illness Personal loss Poor work skills Stressful live events	Self-esteem Skills for life Social and conflict management skills Socioemotional growth Stress management Social support

Recommendation: Invest in early intervention and prevention programs across all disease states. Furthermore, the Administration should look for ways to address risk factors for disease states.

Voluntary Health Care Cost Containment

In New York, a State Medicaid Task Force proposal includes the provision of a Voluntary Health Care Cost Containment Initiative, which gives hospitals and other providers the latitude to make cuts voluntarily. Providers would be closely monitored by the State on meeting targets. If the respective industry voluntary efforts failed, the State could impose utilization controls and rate cuts. Conversely, if the industry achieved savings that beat the identified threshold, the extra savings could be shared between the State and providers in a gain-sharing arrangement. This would encourage providers to work together to do things they have never done before because they have never had an incentive to work together.

Recommendation: Pursue developing and implementing a Voluntary Health Care Cost Containment Initiative.

Payment Reform

With the impending "death" of Fee for Service (FFS), our Association has been working since the passage of Health Care Reform to prepare our system for transition from FFS to an alternate form of payment. This alone will bend the cost curve.

We see tremendous opportunities for pay for performance for providers' role in reducing healthcare expenditures and improving health outcomes.

We have turned to national consultants to help prepare our system for this transition, using health care reform readiness self assessments and operational assessment tools.

In order to pursue meaningful transformations, reforms and cost savings the entire Medicaid financing schema must be considered. Some changes are readily achieved, while others require multi-party conversations. Patient Protection and Affordable Care Act (ACA) and Health Care and Education Reconciliation Act of 2010 (HCERA) have created new possibilities, while pre-ACA federal changes allowed changes, as well. While clearly the state must determine its own options and choices, system delivery participants can offer both general and specific short- and medium-term possibilities. The Association supports an approach of moving toward Providers accepting risk, resulting in both avoiding the disruption of care delivery and achieving significant cost savings.

Recommendation:

- Discussions need to occur with providers around accepting some level of risk, resulting in both avoiding the disruption of care delivery and achieving cost savings.
- Incentives should be carefully tended to such that they not become misaligned anywhere throughout.
- Movement towards Pay for Performance (P4P). PIHP, PAHP and Managed Care Organization (MCO) incentives can be more closely aligned to state benefit with each party sharing responsibility and accountability for overall costs in addition to their component.
- We propose consideration of a multi-year hybrid approach for the current PAHP, as soon as the July 1, 2011 contract year. Provided that rates are actuarially sound and certified as such by CMS, we are prepared to work with the state to craft a blend of capitation and P4P payment mechanisms and FFS to KHS with the express intent of significantly reducing the FFS component and freeing creativity towards results.
- ACA Section 2707 provides for Medicaid Emergency Psychiatric Demonstrations. This section authorizes states to apply for funds to support payments to an IMD for Stabilization purposes beginning in FY 2011. The state should investigate, consider and use KHS as its contract vehicle.
- ACA Section 2706 Pediatric Accountable Care Organization (ACO) Demonstration Project. This section permits states to recognize and make incentive payments to pediatric ACOs; it begins on January 12, 2012. The state should evaluate this approach, as should current and future ACOs. We believe KHS should be a key partner in creating the ACO and in co-managing the care. Beyond this, KHS intends to partner as appropriate with Kansas Plans to establish and/or co-manage to results with ACOs.
- The August 6, 2010 SMD Letter detailed state's opportunities for uses of 1915(i) Waivers for improving access to Home and Community Based Services (HCBS). This opportunity speaks directly to KHPA identification of cost drivers largely being related to the aged and disabled. Kansas has an opportunity working with KHS to take advantage of this opportunity. As a system with a decades-long track record of successfully providing HCBS, we have the competencies.

Managed Care for Long Term Care

In 2008, the Tennessee Legislature unanimously approved a bill that would make Tennessee one of just a few states to contract out its long-term care program to managed health care organizations. The federal government took a full year to approve it. Like laws in Arizona and New Mexico, Tennessee's new law counts on private companies to ensure that a broad array of services — from so-called personal services such as meal preparation, bathing and dressing to home improvements, including wheel chair ramps and even pest control — are provided without additional cost. Two months ago, TennCare CHOICES, opened its doors statewide with the goal of helping 11,000 people remain at home or return to their homes in the first year — all for the same amount the state paid in 2009.

Under the plan, low-income frail elders and adults with disabilities who are medically eligible for nursing home care may opt to receive the services they need in their homes, as long as the total cost is equal to or lower than the cost of a nursing home stay.

It's too early to tell whether CHOICES will accomplish its goals, but so far, more than 40 percent of some 3,300 new enrollees are opting either to move out of a nursing home or avoid going to one in the first place. In addition to

allowing Medicaid to pay for alternative services, Tennessee's CHOICES makes it easier for people to sign up for the program by providing a single point of entry — a caseworker with a local managed care organization.

For the managed care organizations, the financing structure is straightforward. The state gives them a flat monthly fee for each eligible long-term care recipient — whether in a nursing facility or living at home. Some patients will cost more and others will cost less. It's the company's job to ensure that the average cost for all enrollees does not exceed a specified level.

In the mid-1990s, a few states began recognizing the value of serving more long-term care patients in their homes. Alaska, California, Minnesota, New Mexico, Oregon and Washington State now spend more than half of their long-term care dollars on alternatives to nursing facilities. Colorado, Idaho, North Carolina, Texas and Vermont are moving in the same direction. But Tennessee and 23 other states have made less progress, spending less than one-quarter of their long-term care budget on non-institutional care.

At least 10 other states, including Florida, Maryland, New Jersey and Rhode Island, are considering introducing or expanding the use of managed long-term care.

Managed-care companies say they can save money for states by keeping Medicaid patients who need long-term care at home, whenever possible, rather than in more-expensive nursing homes. They use care coordinators to monitor patients to help ensure they're getting the right care in the most appropriate setting. Amerigroup, estimates that it will spend about $37,000 a year for care at home, compared to $55,000 for a year in a nursing home. Over time, those kinds of savings should help hold down Medicaid costs.

Overall, estimated savings for taking a managed care approach to long term care range from 6% to 13% of nursing home care expenditures.

Program of All-Inclusive Care for the Elderly (PACE) Reduces Risk of Long Term Nursing Facility Placement

The PACE is a managed care program that combines traditional health care coverage with coverage for long term care services. The provider accepts a captivated payment rate in the form of a monthly premium to provide all Medicaid/Medicare long term care and medical services. This includes in-home services that might otherwise be accessed through the HCBS waiver program, as well as nursing home services. The capitated rates are paid by KDOA, KHPA and CMS. By federal regulation, the State must negotiate a rate that is at least 5 percent less than the adjusted historical average Medicaid costs. The State benefits from this guaranteed savings factor and the predetermined all-inclusive payment rate. The beneficiaries benefit from a seamless health care network that focuses on keeping individuals healthy and independent. An average of 253 participants per month were enrolled in PACE, which has projects in the Wichita and Topeka areas.

A study published in Gerontology in 2004 examined overall risk and predictors of long-term nursing home admission within the Program of All-Inclusive Care for the Elderly (PACE). Despite the fact that 100% of the PACE participants were nursing home certifiable, the risk of being admitted to a nursing home long term following enrollment from the community is low. The presence of some reversible risk factors may have implications for early intervention to reduce risk further, although the effect of these interventions is likely to be modest. Individuals who received long-term care in a nursing home prior to enrollment in PACE remain at high risk of readmission, despite the availability of comprehensive services.

Recommendation: Examine opportunities for managed care for long-term care that further enhance existing efforts by the PACE program.

Home and Community Based Services Saves Investment in LTC

According to the Kaiser Commission on Medicaid and the Uninsured, on average, Medicaid spending is $26,096 for each person receiving services in a nursing facility compared to $9,459 for home and community-based services for each older person or adult with a physical disability.

However, the Medicaid program has a built-in bias toward nursing-home care, which is an entitlement. Home- and community-based services are an additional option are available through a waiver.

"A state that offers Medicaid doesn't have the option of not paying for nursing facilities under Medicaid, while they do have control over whether to pay for home/community-based services," says Lisa Alecxih, an expert on long-term care financing and senior health insurance issues, and a vice president of the Lewin Group. "Now, when states are facing really tight budgets, they may consider cutting home- and community-based services that actually save them money, just because they do have that option."

A recent report from the UnitedHealth Center for Health Reform and Modernization suggests that national savings from modernizing LTC Medicaid, and substituting home- and community-based care for nursing home admissions, could be as high as $140 billion over the coming decade. Some $60 billion of that sum would accrue to the states.

Those savings could be used to pay for added enrollment in community-based services and to improve provider payments and access. The federal government could broaden state authority to create new LTC models and offer financial incentives. Meanwhile, states could take practical steps such as adopting managed long-term care programs, investing savings from nursing home diversion programs into community-based care, and offering consumer incentives for managed long-term care.

Recommendation: Continue investing in cost effective HCBS Programs.

Mental Health and Aging

Studies say that 18-25 percent of older adults in the community have mental health needs. In nursing care and personal care facilities the number increases. Some studies show that 50 percent of older adults in nursing homes suffer with depression.

New perspectives are evolving on the nature of mental health services for older adults and the settings in which they are delivered. Far greater emphasis is being placed on community-based care, which entails care provided in homes, in outpatient settings, and through community organizations. The emphasis on community-based care has been triggered by a convergence of demographic, consumer, and public policy imperatives. Of those living in the community, approximately 30 percent, mostly women, live alone (U.S. DHHS, AoA & AARP, 1995). Most older persons prefer to remain in the community and to maintain their independence. Yet living alone makes them even more reliant on community-based services if they have a mental disorder.

Service delivery also is being shaped by public policy and the emergence of managed care. The escalating costs of institutional care, combined with the recognition of past abuses, stimulated policies to limit nursing home admissions and to shift treatment to the community (Maddox et al., 1996). **Mental disorders are leading risk factors for institutionalization (Katz & Parmelee, 1997). Therefore, to keep older people in the community, where they prefer to be, more energies are being marshaled to promote mental health and to prevent or treat mental disorders in the community. In other words, treating mental disorders is seen as a means to stave off costly institutionalization—resulting either from a mental disorder or a comorbid somatic disorder. An untreated**

mental disorder, for example, can turn a minor medical problem into a life-threatening and costly condition. Problems with forgetting to take medication (e.g., with dementia), developing delusions about medication (e.g., with schizophrenia), or lowering motivation to refill prescriptions (e.g., with depression) can increase the likelihood of having more severe illnesses that demand more intensive and expensive institutional care. Therefore, promotion of mental health and treatment of mental disorders are crucial elements of service delivery.

Primary care is generally not well equipped to treat chronic mental disorders such as depression or dementia. It has limited capacity to identify patients with common mental disorders and to provide the proactive followup that is required to retain patients in treatment. To ensure better treatment of late-life depression in primary care, there is heightening awareness of the need for new models for mental health service delivery (Unutzer et al., 1997a). New models of service delivery in primary care include mental health teams, consultation-liaison models, and integration of mental health professionals into primary care (Katon & Gonzales, 1994; Schulberg et al., 1995; Katon et al., 1996, 1997; Stolee et al., 1996; Gask et al., 1997). Models that integrate mental health treatment into primary care, while thus far designed largely for depression, also may have utility for other mental disorders seen in primary care. Nevertheless, primary care is not appropriate for *all* patients with mental disorders. Primary care providers can be guided by a set of recommendations for appropriate referrals to specialty mental health care (American Association for Geriatric Psychiatry, 1997). This research further supports the work between the Association of CMHCs of Kansas, Inc., the Kansas Association for the Medically Underserved, and Kansas Health Solutions. The opportunity certainly presents itself to incorporate mental health and aging into pilot efforts.

Recommendation: Promote and support coordinated and collaborative pilot projects inclusive of mental health, substance abuse, aging, and primary care safety net systems that build on existing pilot efforts.

The Affordable Care Act of 2010 offers several opportunities and funding including:

1. Hospital Readmission Reduce Incentives (Sec 3025)
2. National Payment Bundling pilot focused on bundling for episodes of care (not just DRGs) (Sec 3023)
3. Community-based Care Transitions program promoting partnering with community-based organizations (Sec 3026)
4. Independence at Home Demonstration starts in 2012 with Medicare paying for house calls and a focus upon chronic care (Sec 3024)
5. Community Health Teams created to support interdisciplinary team infrastructure and address workforce needs for medical homes model (Sec 3502)
6. Medicaid Health Homes for Chronic Conditions includes 90% federal match (Sec 2703)

Recommendation: Maximize opportunities under the Affordable Care Act of 2010.

Gatekeeper Programs Are Cost Effective for Keeping Older Adults Independent

A 10-year, comprehensive program aimed at keeping older adults in the Cleveland, Ohio, area safe and independent in their own homes has proven to be both successful and cost effective, according to a report published in a recent issue on *Home Healthcare Nurse.* The Gatekeeper Program's goal is to provide "linkages to community resources to delay or prevent institutional care for older adults residing in the program's service area," explain the authors. The intervention and case management program uses trained volunteers from the community – employees of local

businesses and organizations – to identify and refer older adults (age, 60 years and older) in need of assistance. Each referral is reviewed by a nurse/social worker team, followed most often by an unannounced joint visit to the elder's home. The team assess the older adult's physical health and psychosocial needs, develops a plan in conjunction with the elder to link him or her to appropriate community resources, then manages the case for an average of 11 months.

Community resources linked most frequently for the program's clients include: Home health agencies; transportation services; meals on wheels; adult day care, physical health care and mental health care.

"While other case management programs exist, they are traditional in scope," note the authors. "Older adults must agree to be referred to those programs for assistance. The Gatekeeper Program does not wait for the referral. Despite making unscheduled initial visits, 95% of older adults contacted agree to be helped."

The most frequent reasons given by volunteers for referring older adults to the program are: cognitive problems, lack of support, physical impairments, falls, and financial difficulties. These reasons coincide with several known risk factors for nursing home admission, the authors point out.

Program outcomes and cost benefits were analyzed for the period 2001-2008. Key findings include:

- Emergency department visits decreased by 66% during the first three months following assessment and continued to be significantly lower throughout the first year.
- Hospitalizations decreased by 50%.
- Cost savings totaled nearly $14 million.

"The program is unique in that it is proactive and does not assume that the older adult will call for assistance or has a support system in place to call for them," the authors explain, adding that the program reaches out "to those older adults who might not otherwise be found until they are in crisis."

Recommendation: Implement a gatekeeper program targeting older adults who are at risk of institutionalization.

Medicaid Expansion Benchmark Plan

On January 1, 2014, Medicaid will expand to cover more Kansans who are now uninsured, reducing the uninsured rate in Kansas from 11% to 5%. The Affordable Care Act of 2010 requires that most of these newly enrolled individuals be entered into benchmark plans, which have traditionally been less comprehensive than standard Medicaid coverage. However, the ACA also mandates several important improvements to benchmark coverage. States are not required to provide benchmark coverage, and may instead enroll all beneficiaries in standard Medicaid. To date, most states have opted not to use their benchmark authority provided for in the Deficit Reduction Act of 2005.

Medicaid law allows for certain populations to be exempt from benchmark coverage. The ACA carries over these exemptions to individuals who are newly eligible for Medicaid in 2014. Newly eligible individuals from the following groups are excluded from benchmark coverage and must be enrolled in traditional Medicaid:

- Blind or disabled individuals, regardless of eligibility for SSI
- Individuals who are eligible for both Medicaid and Medicare
- Inpatients in hospital, nursing facility or intermedidate care facility for the mentally retarded
- Medically frail and special needs individuals

Benchmark plans will be required to cover at least a specified set of "minimum essential benefits." These benefits must include mental health and substance abuse treatment services, rehabilitation and "habilitative" services – a requirement that does not apply to traditional Medicaid. They must also include prescription drugs. The ACA also applies the 2008 Mental Health Parity and Addictions Equity Act to benchmark plans. The parity law requires group health plans that offer mental health and substance abuse benefits to offer them at levels no more restrictive than those applied to medical surgical benefits. This means that not only must benchmark plans offer mental health and substance abuse benefits, they must be offered at parity with medical surgical benefits.

States can choose benefits that are actuarially equivalent to the federal employee health benefits program, the state's own state employee health benefits plan, the HMO with the largest non-Medicaid enrollment in the State, the actuarial equivalent of any of these plans, or the Secretary approved coverage. States that want to make their existing Medicaid benefit package available to the early expansion group may be able to do this through the Secretary approved coverage option.

The result of these changes is that Medicaid beneficiaries enrolled in benchmark plans in 2014 could have access to far greater mental health and substance abuse benefits than currently offered by most benchmark plans.

If designed well, this could save the State SGF that is currently committed to serving the uninsured who are mentally ill and present to a CMHC for services. What that amount of savings is will be dependent upon the benefit package.

Recommendation: Work with SRS, KHS, the Association of CMHCs of Kansas, and mental health system stakeholders to determine an adequate mental health and substance abuse benefit package for the benchmark plan.

Early Adopter (certain aspects)

Kansas should analyze the impacts and benefits of becoming an early adopter State in the context of health care reform, choosing only to pursue certain aspects (i.e. expansion of Medicaid before 2014). There are financial incentives in becoming and early adopter and our MCO, Kansas Health Solutions, stands ready to assist in the analyses and transition planning, as well as doing its part to assure network adequacy for new demand be it 2014 or sooner.

Managing Mental Health Prescription Drugs

With the growing concern over increasing costs of pharmaceutical expenditures in the Medicaid program, and the growing costs of health care overall, we do appreciate the efforts of the KHPA to explore ways to manage those costs. We support their efforts to pursue enhanced safety for Medicaid beneficiaries while improving health outcomes for those we serve in the public mental health system. We simply disagree with the approach they have taken in past years. Our concerns are that prior authorization (PA) or a PDL is a drastic measure that could threaten the safety, health, and ultimately jeopardize the recovery process for a person with a mental illness and ignores effective alternatives which we do support. Mental health system stakeholders oppose any effort to repeal the existing statutory exemption language which prevents mental health prescription drugs from PA or a PDL.

The Association and its members value the importance of the provider/consumer relationship and believe that treatment decisions are best-made through dialogue, evaluation of personal preferences, treatment goals, and clinical judgment on what course of therapy is most likely to contribute to recovery.

It is important to note that:

- Optimal treatment match is critical.
- Gaps in therapy lead to relapse and hospitalization.
- Relapse has direct and irreversible clinical consequences.
- Patients with severe mental illness have unique needs.
- PDLs are used to achieve cost savings, not address safety issues.
- Often savings in one part of any given mental health system (in this case formulary costs) will cause a rise in expenditures in another part of the system, such as patient visits or hospitalization.
- There are meaningful and effective alternatives to a PDL that need to be implemented (see attachment).

The mental health advocacy community feels strongly that the Medicaid agency can and should begin implementing practice guidelines, provider feedback and retrospective reviews to identify prescribers who deviate and focus on providing support and specialty consultation – all in such a way that ensures optimal results which will address safety concerns and will realize cost savings. With a 75 percent federal match, the minimal investment needed could come from any of the following areas: underwriting by a pharmaceutical company; savings realized from mental health drugs going generic in 2011 and 2012; or from other areas of possible savings identified in this document. It should be noted that this program was free to the State of Kansas, designed to meet the needs of the client (KHPA), and was a program designed to help States evaluate mental health prescribing practices and improve care. The program results for the first 19 months were: 33% reduction in patients prescribed the same antipsychotic medications from multiple doctors; 31% reduction in patients who fail to refill an agent for bipolar disorder within 30 days of the prescription ending; and 21% reduction in patients on five or more psychotropic medications. This resulted in $1.7 million in annualized mental health pharmacy cost avoidance. The agency has said these types of programs don't see savings unless paired with other pharmacy control tools. Care Management Technologies (formerly known as CNS) has assured us their program takes into account concurrent programs when conducting analyses of the impact of their program. Therefore, the results reported are as closely aligned to this program as possible. In addition, there have been independent audits to verify CMT's methodologies as confirmed that its methodologies are sound and can be linked to the program. The $1.7 million in savings addresses previous concerns of the agency without restricting access and achieves cost savings.

A retrospective drug utilization review program which would include pharmacy claims edits to prevent therapeutic duplication, overdosing and adverse medication-related reactions should be implemented without restricting access to medications. We note that one study has shown a 6.5 percent decrease in total drug expenditures in States with Retro-DUR; and 4.9 percent decrease in expenditures per recipient in States with Retro-DUR.

Recommendation: Implement practice guidelines, provider feedback and retrospective reviews for Medicaid mental health prescription drugs.

Additional Pharmacy Savings

Outlined below are seven ideas for additional savings that can be achieved in Medicaid pharmacy as well as in the State employee health benefits plan.

1. The State receives millions of dollars from brand name research pharmaceutical companies in drug rebates, as required by federal law (Omnibus Budget Reconciliation Act of 1990). The generic drug manufacturers are also

required by this same federal law to provide rebates to the Medicaid program. Of the brand name drugs, 15.1 percent of the Wholesale Acquisition Cost (WAC) or the best price that they gave any commercial customer (whichever is greater) is the rebate required for band name drugs, plus a Consumer Price Index penalty. This guarantees the States get the best price on every brand name product until it is off patent. In the same law, it required the generic manufacturers to give a flat 11 percent rebate. In the Affordable Care Act of 2010, OBRA 90 requirements on drug manufacturer rebates was updated and changed to require brand name manufacturers to rebate the State Medicaid program on all new brand name drugs going forward from March 23, 2010, the amount of 23.1 percent or best price, whichever is greater, plus the CPI penalty. For generics, a flat 13 percent. Our understanding is there was a missed opportunity in Kansas in invoicing the full 11 percent on generics, with a conservative estimate of increased collections by $2 million annually. Has Kansas been invoicing the full 11 percent? Has Kansas adjusted for the changes provided for in the ACA as it relates to rebates?

2. According to research, generic utilization rate is 64 percent in Medicaid nationally, more than 10 percent lower than in the general population, suggesting a potential for significant savings. What rate is generic utilization occurring in the Kansas Medicaid program? Is there an opportunity to capture savings here?

3. Kansas could participate in a multi-State drug purchasing consortium and negotiate better prices. This would result in $2.2 million in savings.

4. We know there is legislation pending in other States (AR House Bill 1308; IL SB 1759; IN SB 492; OK HB 1056) that allows for competitive bidding on generics. Kansas could explore this which would create a preferred drug list for generics which would also result in additional generic rebates through generic supplemental rebates. What we don't know is what kind of savings this would create but it is worth exploring.

5. E-Prescribing technology to improve decision-making can save millions when fully implemented. What is the status of e-prescribing in Kansas? E-prescribing technology brings new technology to the hands of prescribers to improve decision-making that can save millions of dollars when implemented. By providing up-to-date drug information to allow providers to make more informed drug therapy decisions and to better monitor patient compliance, as well as by providing clinical alert tools for screening combinations of prescription drugs and drug products to check compatibility at the point of care, thus helping to avoid potential interactions and adverse events. Outcomes are also improved by providing access to dosing information and dosage limits. Costs are reduced, continuity and coordination of care between providers is improved, and prescribing efficiency is enhanced. Florida's experience provided for 3,000 participating prescribers and generated 2 year savings of $50 million. Mississippi generated $14.4 million in savings for just 225 prescribers. It is believed that KHPA can see $2 million in savings immediately by implementing e-prescribing.

6. According to the U.S. Department of Health and Human Services, Alabama is the first State to adopt use of actual acquisition costs (what the pharmacy pays the wholesaler) as the benchmark for drug reimbursement, and expects to save six percent ($30 million) of its pharmacy costs in the first year of implementation. No State Medicaid program buys or stores pharmaceutical drugs for the Medicaid program. The State Medicaid program simply reimburses the pharmacy for the costs and the State determines what they pay for reimbursement and how they reimburse the pharmacy. Is actual acquisition cost a viable option for the Medicaid program in Kansas?

7. The State could reduce State's coinsurance coverage for State employees by 5 percent on non-generic prescriptions to encourage use of generics. We understand this would result in $2.2 million in savings.

Recommendation: Implement each of the seven opportunities for pharmacy savings.

Medicaid Cost Sharing

States may impose cost sharing on most Medicaid-covered services, both inpatient and outpatient, and the amounts that can be charged vary with income. To encourage the use of lower-cost drugs, such as generics, State may establish different copayments for non-preferred versus preferred drugs. A letter to the Governors from HHS Secretary Sebelius, dated February 3, 2011, outline maximum allowable copayments.

Recommendation: Examine what cost sharing is occurring in Kansas Medicaid presently and identify opportunities that might be worthwhile to explore that would be affordable for Medicaid recipients in Kansas.

All Mental Health Services Coordinated and Contracted For Under One Agency

The current structure in place in Kansas gives SRS the delegated function for Medicaid mental health. The agency also is the State Mental Health Authority with all mental health program and funding for the State of Kansas within that structure. This works very well in Kansas and ensures coordinated policy and financing occurs where system planning and implementing is congruent. This reduces the silo effect and fragmentation for mental health as all decisions are occurring within one agency.

KHPA manages a very small contract with a managed care organization (Cenpatico) for mental health services for HealthWave 21 beneficiaries. Neither the contract, nor the services provided as part of the contract are coordinated in any way with SRS, who has the significant contract for Medicaid mental health services. The HealthWave 21 mental health benefits should be integrated into the managed care contract SRS has for Medicaid mental health services to ensure coordination and continuity.

Recommendation: Support all mental health services purchased by the State be coordinated and contracted for within the single State agency that manages and oversees mental health programs, which is currently SRS. This would include Medicaid mental health.

Mandating Coordination of Care

There are coordination issues across primary care, substance abuse, mental health, aging, and disability services. While each system is encouraged to coordinate care, nothing mandates it. To influence provider behavior, you need greater strings on the money.

Recommendation: Direct Executive Branch agencies who purchase health care services to contractually require coordination and integration of care and have measureable outcomes that demonstrate coordinated care. In addition, align budgetary incentives for community-based agencies to work together to achieve coordinated, integrated care.

Savings in Child Welfare

The Washington State Institute for Public Policy was directed by the 2007 Washington Legislature to estimate whether evidence-based programs and policies and reduce the likelihood of children entering and remaining in the

child welfare system, including both prevention and intervention programs. They found the some evidence-based programs work; they found several programs that can generate long-term monetary benefits well in excess of program costs; they estimate over a five year period, implementing those programs would net savings of between $317 million and $493 million. Some of the evidence-based programs identified include:

- **Chicago Child Parent Centers.** These school-based centers provide educational and family support services for families living in high poverty neighborhoods. The centers aim to provide a stable learning environment from preschool through the early elementary school years and provide support to parents so that they can be involved in their children's education.

- **Dependency (or Family Treatment) Drug Court (California, Nevada and New York).** Dependency Drug Courts provide frequent court hearings for substance abusing parents involved in the child welfare system. These courts offer intensive monitoring, substance abuse treatment, and a system of rewards and sanctions for treatment compliance. The goal is to bridge the gap between child welfare and criminal justice for families with substance abuse problems, and increase the probability of family stability.

- **Family Assessment Response (Minnesota)** is an alternative response system for families referred to child welfare who do not warrant an immediate investigation. This strategy provides support and services to families without an incident-focused investigation of harm.

- **Flexible Funding (Title IV-E Waivers in Oregon and North Carolina).** The Title IV-E waivers allowed states flexibility in spending federal dollars previously earmarked for foster care maintenance. States were encouraged to expand existing services or implement new services with the aim of improving outcomes for children in the child welfare system. The new services were required to be "cost-neutral."

- **Healthy Families America** is a network of programs that grew out of the Hawaii Healthy Start program. At-risk mothers are identified and enrolled either during pregnancy or shortly after the birth of a child. The intervention involves home visits by trained paraprofessionals who provide information on parenting and child development, parenting classes, and case management.

- **Intensive Case Management for Emotionally Disturbed and/or Maltreated Youth.** Programs under this heading include some that have been referred to as "Wraparound" or "Systems of Care." These programs emphasize providing individualized coordinate services among a variety of agencies and organization s and allow the child to remain in the community. This approach is considered more flexible and tailored to individual circumstances than usual services. For this analysis, emphasis was placed on programs directed toward children with serious emotional disturbances who are in foster care or referred by the child welfare system.

- **Intensive Family Preservation Services Programs** are short-term, home-based crisis intervention services that emphasize placement prevention. The original program, Homebuilders®, was developed in 1974 in Federal Way, Washington. The program emphasizes contact with the family within 24 hours of the crisis, staff accessibility round the clock, small caseload sizes, service duration of four to six weeks, and provision of intensive, concrete services and counseling. These programs are intended to prevent removal of a child from his or her biological home (or to promote his or her return to that home) by improving family functioning. For this analysis, we have presented the effects of all such programs together. We have also separated these programs into two categories:

    (1) those that serve families with children at imminent risk of being removed from home,
    (2) those that serve families with a child already placed out of home.

- **Iowa Family Development and Self Sufficiency Program (FaDSS).** This program is targeted to women at risk of long-term welfare dependence. Families who volunteered for FaDSS were then randomly assigned to treatment or regular welfare-to-work programs. The intervention involves home visits, assessment, goal-setting, support services and service referral, advocacy, funds for special needs, and group activities.

- **Nurse Family Partnership for Low Income Families**24 provides intensive visitation by nurses during a woman's pregnancy and the first two years after birth; the program was developed by Dr. David Olds. The goal is to promote the child's development and provide support and instructive parenting skills to the parents. The program is designed to serve low-income, at-risk pregnant women bearing their first child.

- **Parent-Child Interaction Therapy** aims to restructure the parent-child relationship and provide the child with a secure attachment to the parent. Parents are treated with their children, skills are behaviorally defined, and all skills are directly coached and practiced in parent-child sessions. Therapists observe parent-child interactions through a one-way mirror and coach the parent using a radio earphone. Live coaching and monitoring of skill acquisition are cornerstones of the program.

- **Parents as Teachers** is a home visiting program for parents and children with a main goal of having children ready to learn by the time they go to school. Parents are visited monthly by parent educators with some college education. Visits typically begin during the mother's pregnancy and may continue until the child enters kindergarten.

- **SAFE Homes (Connecticut)** are group foster homes designed to serve as short-term placements while appropriate, longer term foster placements are found. SAFE Homes aims to keep siblings together and maintain children in their home communities when they are first removed from home.

- **Subsidized Guardianship (Illinois)** is a strategy for increasing placement permanency by offering legal, subsidized guardianships for kin or foster care providers. These guardianships differ from formal adoption in that they do not require the legal severance of the relationship between the child and his or her biological family.

We know from experiences in Kansas that the Family Assessment and Referral (FAR) Program to divert children from foster care placemen can provide services to families in contact with law enforcement or SRS because of abuse, neglect, behavior problems or substance abuse of youth/parents. The FAR is an immediate and intensive assessment of a child/family at the point where a child in jeopardy of being taken out of their home by police or SRS. This keeps families intact and children in their homes. Families then get the help they need with treatment and other social skills to remain intact. The successful diversion from three pilot projects in Kansas was an 84% diversion from foster care placement for such children. The savings by implementing this program statewide would be significant.

Recommendation: Invest in programs that have been outlined above. Two specific recommendations noteworthy are increasing the State's investment in family preservation as well as investing in the Family Assessment and Referral Program to divert children from foster care placement, recognizing a diversion rate of 84%, which results in significant savings in child welfare expenditures.

"Optional" Medicaid Mental Health Services Saves Money

To participate in Medicaid, Kansas must provide certain covered services which are federally mandated. Another set of services are "optional" under the federal statute. These "optional" services were added to the federal program

mostly as ways to save the states money, and to provide federal financial assistance for services which states were providing without federal matching funds. Whenever Kansas has chosen to cover optional Medicaid services, it has been done for the purpose of reducing costs in mandatory services or to obtain federal matching funds for services previously paid for with state dollars.

"Optional Services" include lower cost alternatives to mandatory services. Many optional services are lower cost services which reduce the use of higher cost, mandatory services. For example nurse practitioner services and licensed professional services such as podiatrists, psychologists, and nurse anesthetists are "optional" but reduce the use of higher cost, mandatory physician services. Similarly, optional Home and Community Based Services (HCBS) replace more expensive mandatory nursing home services.

Home and community based mental health rehabilitation services, like psychosocial rehabilitation (PSR) have been proven to reduce the frequency of involuntary hospitalization in state hospitals which, for most adults, is paid for with 100% state funds. We know it costs on average, $428 per day for treatment at one of our State psychiatric hospitals; $80 per day on average to be incarcerated at Larned Correctional Mental Health Facility; $10 per day on average for Medicaid expenditures for community-based mental health treatment; and $22 per day on average for Medicaid expenditures for the most chronic mental health conditions. This is consistent with other data which confirms community-based treatment for mental illness is the best value. It is also important to note that investing in community-based mental health services directly lowers healthcare costs. Treatment for mental disorders is associated with a 20 percent reduction in the overall use of health care services according to research by *Lave, J. The cost offset effect.* At a time when the State is struggling with containing the costs of health care, paying for the cost of community-based mental health treatment is part of the solution to our State's budget crisis.

The Americans with Disabilities Act mandates community services. Even though many community based services for people with disabilities are considered optional under the federal Medicaid statute, compliance with the Americans with Disabilities Act (42 USC §12101-12103) is not optional. Since the U. S. Supreme Court decision in Olmstead v. L.C. and E.W., 527 U.S. 581 (1999), it has been clear that state's cannot design their Medicaid programs in a manner which unnecessarily forces people with disabilities into institutional settings to receive Medicaid services. The Court specifically noted the HCBS waivers as the method for insuring that integrated settings with adequate services are available within the state's Medicaid system as alternatives to institutional services. While states have considerable flexibility in how they configure their HCBS services, elimination of community based alternatives violates the requirements of the Americans with Disabilities Act.

Although the federal Medicaid statutes label some services "optional" they are not optional for children who have a medical need for the services. Under statutory provisions for "Early and Periodic Screening, Diagnosis and Treatment" for children, the federal law requires states to cover any "treatments" identified in an EPSDT appointment.

Under this provision, any optional Medicaid service becomes mandatory for any child for whom it is considered "medically necessary".

Recommendation: Support the optional Medicaid mental health services in the Medicaid State Plan, as doing otherwise will increase costs to the State by driving people to higher cost mandatory services or by losing federal matching funds for services the State would need to provide with SGF dollars.

We appreciate the opportunity to provide the Administration with these ideas and input. We strongly encourage provider and stakeholder participation throughout the decision making process to ensure broad-based input and the greatest opportunity for buy-in.